Texas Department of Insurance
Division of Workers' Comp
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

MEDICAL EDGE HEALTHCARE GROUP
9229 LBJ FREEWAY
DALLAS TX 75265

Respondent Name

INDEMNITY INSURANCE CO OF N AMERICA

Carrier's Austin Representative Box

Box Number 15

MFDR Tracking Number

M4-11-4136-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Broadspire denied our claim, 1st for timely filing. We sent a request for reconsideration on 05-24-11 that shows we sent them our first claim on 04-29-10 but they denied it also. Please have them pay our claim."

Amount in Dispute: $1,008.40

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "First of all, this dispute involves the date of service 4/14/10 as indicated on the DWC-60 Table of Disputed Services and also on the MR-100. The MR-100 indicates that the postmark date in which the dispute was received from Requestor was 7/15/11. Pursuant to DWC Rule 133.307(c)(1), request for medical fee dispute resolution must be filed within one year of the date of service unless there are issues of compensability, extent of injury, liability, or medical necessity. There are no issues of compensability, extent of injury, liability, or medical necessity surrounding this date of service; thus, the dispute was not timely file within one year of the date of service…" "Additionally, Requestor did not timely send this medical bill to Respondent for payment. Enclosed please find a copy of the medical bill received from requestor. The bill clearly shows that the original receipt date was 7/26/10, more than 95 days from the date of service. Thus, the EOB reflects that the bill was denied due to the lack of filing within 95 days of the date of service."

Response Submitted by: Downs-Stanford, PC, 2001 Bryan Street, Suite 4000, Dallas, Texas 75201

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 14, 2010	72158, A9579	$1,008.40	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated August 18, 2010
   - 110-001– COVENTRY CONTRACT STATUS INDICATOR 01 – CONTRACTED PROVIDER.
   - 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Code PR or CO depending upon liability).
   - 883-022– BASED ON FEE SCHEDULE GUIDELINES, BILLS SUBMITTED AFTER THE 95TH DAY AFTER THE DATE OF SERVICE ARE DISALLOWED.
   - 993– SERVICE DENIED
   - B4– Late filing penalty.
   - W1 – Workers Compensation State Fee Schedule Adjustment.

   Explanation of benefits dated February 9, 2011
   - 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Code PR or CO depending upon liability).
   - W1 – Workers Compensation State Fee Schedule Adjustment $0.00
   - 193– Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - 111-001– COVENTRY CONTRACT STATUS INDICATOR 01 – CONTRACTED PROVIDER.
   - 887-005– THE TIME FOR FILING HAS EXPIRED. $0.00.
   - 900– BASED ON FURTHER REVIEW, NO ADDITIONAL ALLOWANCE IS WARRANTED.

   Explanation of benefits dated May 2, 2011
   - 18 – Duplicate claim service.
   - 476 – $2,283.0 OF THE CHARGES ARE DUPLICATES OF BILL #889-H-1195714-1
   - 886 – REIMBURSEMENT NOT RECOMMENDED AS SERVICE APPEARS TO BE A DUPLICATE OF ANOTHER SERVICE BILLED ON THE SAME DATE OF SERVICE $0.00.

Issues

1. Did the requestor file for medical fee dispute resolution in accordance with 28 Texas Administrative Code §133.307?
2. Did the requestor waive their right to medical fee dispute resolution?

Findings

1. 28 Texas Administrative Code §133.307(c)(1) states in pertinent part that a request for medical fee dispute resolution shall be filed no later than one year after the date(s) of service in dispute or waive the right to MDR. The Division shall deem a request to be filed on the date the MDR Section receives the request. The date of service in dispute is April 14, 2010. The request for medical dispute resolution was received in the Medical Dispute Resolution (MDR) section on July 15, 2011.
2. 28 Texas Administrative Code §133.307(c)(1) states that a request shall be timely filed with the Division's MDR Section or waive the right to medical dispute resolution. The Division finds that the requestor has failed to timely file this dispute with the Division's MDR Section and has therefore waived the right to medical dispute resolution.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October 26, 2011 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.